Wakely
Consulting Group

Washington State Health Benefits Exchange Resources and Needs Assessment

November 1, 2011

One Constitution Center, Ste. 100, Boston, MA 02128

Table of Contents

I. Executive Summary

In July 2011, the HCA engaged Wakely Consulting Group, Inc. (Wakely) to assess Washington's current resources, capabilities, needs and gaps related to the development of the Washington Health Benefit Exchange. The assessment, the results of which are reflected in this report, was intended to identify which functional capabilities necessary to operate the exchange the state currently possesses, where gaps in functionality exist, and provide recommendations as to how these gaps can best be filled as well as to which aspects of existing capabilities might best be leveraged to support the exchange.

To assess the state's existing resources, Wakely conducted interviews with senior officials from a range of existing health care agencies in Washington, including representatives from the Health Care Authority; the Public Employees' Benefit Board (PEBB), the Health Insurance Partnership (HIP), the Basic Health program, and Medicaid. Outside of the HCA, Wakely interviewed staff from the Office of the Insurance Commissioner (OIC)). We also interviewed key vendors, such as third party administrators and consultants, where appropriate, and reviewed a range of publicly available information and documents provided by interviewees.

Wakely then compared Washington's existing infrastructure with the functional requirements of the exchange to identify where gaps in functionality exist that must be filled, as well as to identify existing capacity that may be useful to the exchange. We found that Washington State has a rich array of health care programs, each in possession of the infrastructure components to support its own population and administration, including eligibility determination, customer service, enrollment and billing, health plan procurement, and consumer outreach. In general, we found that, due to the specific requirements for exchange functionality specified under the ACA, most of the existing systems and capacities do not possess the full range of functionality and/or automation required to support the operations of the exchange without significant remediation. However, we did identify several smaller, more discrete instances of functions, processes, and expertise that warrant further study as potentially valuable assets for exchange development.

A summary of some key areas that warrant further study is included in the Table 1, below.

Table 1. Existing Exchange Related Resources, by Agency

Agency	Key Components Warranting Further Study
Basic Health Plan (BHP)	• MBMS system for premium billing and funds flow management
Health Insurance Partnership (HIP)	• Experience developing SHOP-specific functions related to employer billing, collection, and subsidy calculation

	• Experience with designating the health benefit plans offered by participating carriers • Experience marketing to small groups • Broker training and oversight
Medicaid	• Provider 1 MMIS system • Apple Health for Kids program for outreach organization management and performance evaluation to support Navigator program
Public Employee Benefit Board (PEBB)	• Infrastructure to support health plan procurement • Data warehouse • Benefit and product design and implementation
Office of the Insurance Commissioner (OIC)	• Regulatory oversight of health plans • Carrier data collection and review processes • Consumer protection, appeals, and outreach functions • Rate review and financial analytics

II. Introduction

Washington State passed legislation in April of 2011 authorizing the creation of the Washington Health Benefit Exchange. As indicated in the exchange's authorizing legislation, this report should include a discussion of the "administrative, fiduciary, accounting, contracting, and other services to be provided by the exchange", as well as discussion of whether and to what extent there will be "coordination of the exchange with other state programs."

In July 2011, the HCA engaged Wakely Consulting Group, Inc. (Wakely) to assess Washington's current resources, capabilities, needs and gaps related to the development of an exchange. The assessment is intended to identify what functional capabilities the state possesses, where gaps in functionality exist, and to provide recommendations about how to best utilize existing resources, as well as about how identified gaps can best be filled. While it does at times touch on information systems utilized by existing programs as they relate to exchange functionality, this review is separate from the information technology gap assessment that was performed by Cambria, which is focused more specifically on the needs and requirements of the exchange from an IT systems standpoint. Rather, this report will focus on existing business processes, programmatic functions, staff expertise, and other functional attributes of existing programs to assess their ability to support the required business functions of the exchange.

In this paper, we outline the capabilities and resources that will be needed to operate the exchange. We then assess the available resources and capabilities in the state's existing

coverage programs and agencies which parallel and could help meet the operating needs of the exchange. Finally, we identify options for Washington's new exchange to use existing state capabilities, and we discuss the pros and cons of filling the gaps by using existing resources and capabilities.

III. Key Functions and Requirements of the Exchange

Requirements for operating an exchange come from statutory requirements (stated in the Affordable Care Act (ACA)), regulatory requirements (based on guidance issued to date by federal agencies), and operational requirements (dictated by the functions needed for an exchange to carry out its operations). Taken together, the key functions for the exchange can be grouped into 16 core work processes. For convenience, we have further grouped these core work processes into five major business areas, as outlined in Table 1, below.

Table 2. Major Business Areas and Core Work Processes

Major Business Area	Core Work Processes
Exchange Governance & Administration	1. Governance & Oversight
	2. Internal Administration
	3. Financial Management
Operational Systems	4. Eligibility Determination
	5. Premium Tax Credit Administration
	6. Website & Online Shopping
	7. Enrollment, Billing & Collections
	8. Customer Service Call Center
	9. SHOP-specific Processes
Communications	10. Outreach & Marketing
	11. Broker and Navigator Management
QHP Certification	12. Qualified Health Plan (QHP) Certification
	13. Plan Rating System
Regulatory & Reporting	14. Reinsurance & Risk Adjustment Program
	15. Consumer Protections & External Reporting
	16. Exemption Certificates & Appeals of Eligibility

We will discuss each of these core areas in turn, and elaborate the requirements of the exchange in each area.

1. Oversight, Governance, and Program Evaluation

The exchange will be governed by a board, and exchange staff will need to manage board

relations so that the board is fully informed, works effectively, and maintains confidence and trust in the staff. Public board meetings often attract media coverage, so exchange governance structure and meetings communicate a lot about the exchange and reform more broadly. Coordination between the exchange and other state agencies will also be important to effective implementation of health reform across the various state agencies intimately involved in it. Once fully operational, the exchange should develop multi-year strategic plans, annual operating plans, and program evaluation tools to track performance over time, including take-up and enrollment levels of the target markets, and consumer satisfaction. Exchanges should also be able to monitor for unintended consequences such as crowd-out in the employer market or adverse selection.

2. Internal Administration

Washington's legislation creates the exchange as a "public-private partnership that is separate and distinct from the state". This means that, once established, the exchange must have a physical location to support operations as well as the administrative and financial infrastructure necessary to hire staff and operate its business functions. This will require the physical items needed to run the organization, such as office space, furniture, computers, data servers, and phones, as well as the administrative infrastructure needed for a new entity, including bank accounts, an accounting structure, payroll capabilities, as well as human resources policies and employee benefits.

3. Financial Management

An exchange must account for all activities, receipts, and expenditures and provide an annual report to the Secretary. An exchange will be subject to audits and investigations. In addition to strong accounting and financial management reporting systems, exchanges will need to be self-sustaining beginning in 2015. Specifically, SHOP exchanges will need to coordinate payments from employers to plans, brokers, and vendors. Exchanges are required by the ACA to publish the costs of licensing, regulatory fees, and any other payments required by the exchange. The exchange will also need to be self-sustaining. Exchanges will need data warehousing functions to manage these financial functions and be able to generate reports and receipts. Outsourcing and vendor management functions will also be needed. Periodically, the exchange will need to reconcile billing and collections with QHPs and possibly the Treasury as well.

4. Eligibility determination

The ACA requires an eligibility system that would determine an individual's eligibility for Medicaid, CHIP, and exchange premium and cost-sharing subsidies. The exchange would need to collect the information needed for eligibility determinations, transmit it to the federal hub for verification, and then return eligibility decisions in real-time (for most customers).

Federal guidelines indicate that customers should have the same, high-quality shopping experience regardless of which door (Medicaid, CHIP, or exchange) they utilize. The system should accommodate robust performance evaluation and management functions. The guidelines state that the federal government will establish an approach to verification from its agencies so that states will not have to independently establish their own interfaces and connections. The 1.0 version of the federal guidelines does not provide in-depth specifications for the technical architecture. However, the guidelines do identify several existing federal standards that exchange IT systems will need to comply with. These include HIPAA requirements, Section 6103 of the Internal Revenue Code, accessibility standards for people with disabilities, and the National Information Exchange Model (NIEM) to facilitate common data exchange. Depending on whether Washington elects to establish an eligibility determination system that is separate from the exchange website, the system will also require an accompanying call center and case workers.

States will need to consider the impact of using modified adjusted gross income (MAGI) for income-based eligibility determinations and non-income based eligibility determinations, such as for the elderly and disabled population, and when and how to conduct eligibility redeterminations.

5. Premium Tax Credit Administration

The exchange must determine individuals' eligibility for premium tax credits and cost sharing subsidies and include a premium tax credit calculator on its website that is integrated with the initial eligibility process and capable of providing subsidy calculations in real time. It also must coordinate the payment of these subsidies and integrate the determined level of subsidy with the billing and collections interface to QHPs offered through the exchange. Submitting information to Treasury and HHS will be necessary, especially for those individuals who request and receive an advance tax credit. Coordination and reconciliation with QHPs will also be necessary, as the exchange will be the source of record for enrollment, but the actual funds flow for tax subsidies will be from the US Treasury to the QHPs or to the exchange if Washington elects to have the exchange aggregate premiums.

6. Website & Online Shopping

Exchanges are required to establish a website that provides standardized comparative information on QHPs. Exchanges must inform consumers about the eligibility criteria for Medicaid, the Children's Health Insurance Program (CHIP), and other applicable state and local programs. The exchange must provide a cost calculator that calculates the cost of coverage after the application of a premium or cost-sharing tax credit. This means that the exchange must have a mechanism for "grabbing" rates from carriers. The internet portal must also provide information about enrollee satisfaction. In addition, the exchange should provide decision support tools to help consumers choose a plan.

While not explicitly described in ACA, SHOP exchanges will need to display for employees the coverage tier selected by their employer and the cost of plans to the employee taking into account the employer contribution.

7. Enrollment, Billing, and Collections

The exchange will need to be able to enroll both individuals and small groups into health plans. This should include a process for confirming and communicating about plan selection, enrollment date, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized), dollar flows, effective date of coverage, and fulfillment of enrollment process and materials by carrier. There should be automated data exchange between the eligibility, enrollment, and billing systems, so that consumers do not need to re-enter or re-transmit basic information at each step. The exchange will need to generate bills, process electronic funds transfer and/or credit card payments, and generate receipts. Uniform policies should be established across carriers for enrollment, billing cycles, collections, late payments, and termination for non-payment.

Many of these functions apply to both the individual and SHOP exchanges. The SHOP exchange will also need to carry out a number of additional functions. For example, the SHOP exchange will need to establish an employer verification process, as well as a simple and streamlined employer application system that will expedite the collection of necessary data from employers, including an employee census. Employers must be able to select a tier of coverage and indicate their contribution to that coverage. Employees will need to be issued a passcode to access the exchange, and then be able to select among plans within the specified tier (employee-choice model). Although not entirely clear in the ACA, there is an interpretation of ACA that would also allow, in addition to the employee-choice model, a conventional health insurance offering in which employers select for employees the QHP, tier of coverage, and benefit plan on the tier (single-source coverage). Additional federal guidance is expected to clarify this issue. Exchanges will also need to develop a system for making mid-year additions/deletions as well as a system for administering COBRA coverage.

Exchanges are required to provide for open enrollment periods, including an annual open enrollment period as well as special enrollment periods for qualifying events. The NPRM contemplates rolling enrollment for SHOP, meaning that plan renewal occurs when the group's anniversary date comes up, with premiums fixed for a year from the employer's anniversary date. It is likely that Washington will have flexibility to establish its own small business enrollment process, including qualifying events. However, decisions on issues such as open enrollment cycles will need to be considered within the context of the existing small group market.

8. Customer Service

Exchanges are required to provide a toll-free telephone hotline to provide for consumer assistance in addition to the website described. Exchanges should consider the need for customer service to respond to individual, employer, and broker queries, any difficulties with website functionality or navigation, as well as problems in transmission of enrollment and premium information to plans.

To operate a customer service call center, the exchange will need customer service protocols (automated and in manuals) and customer tracking tools and databases. Telephone and in-person staff will need to be hired and trained. In developing customer service support, the exchange should consider accessibility of the exchange to people whose primary language is not English, and to people with disabilities.

9. SHOP Specific Functions

The SHOP exchange serving small businesses will need to provide a number of functions specific to the small group market and provide an efficient and administratively simple process for small employers similar to or better than the standards currently found in the commercial market. The SHOP exchange will need to provide online shopping services for employers, such as online premium quote generation, plan selection options, and employer account set up. Once an employer enrolls, the SHOP exchange must provide an employer verification process to confirm eligibility of employees, information on employer and employee contribution levels, an employee cost calculator, and employer invoicing and payment receptacles. The SHOP exchange must also be capable of providing aggregated payments to carriers; customer service protocols for employers, employees and brokers; and a calculator to assist employers in determining their eligibility for tax credits (actual determination is a function of corporate tax filings and determination by the IRS). With respect to brokers or other producers, the exchange must establish broker training and sales tools, broker reporting and analytics, and uniformity requirements among carriers.

10. Outreach & Marketing

Washington's exchange will need communications and outreach programs to explain the role of the exchange to Washington residents and small employers. In addition, the ACA specifies that exchanges must consult with stakeholders, including representatives of small businesses and self-employed individuals. For most people who are not sick, health insurance is a "grudge buy"—not something they like or want to spend a lot of time exploring, nor do they savor the purchase. Yet it is a major outlay, ranging from $3,000 to $15,000 per year, and carries great significance once the enrollee becomes ill. Therefore, effective communications to a large population of potential exchange customers is a critical function, and the relevant skillsets are far more typically available in the private than the public sector. This requires a marketing campaign, including branding, logo, paid and "earned" media strategies, etc.

11. Broker and Navigator Management

The Exchange has a range of options in structuring its relationship with health insurance producers, whether through a more traditional broker function or as structured as part of the ACA-required Navigator program, which is intended to supplement the exchange's outreach and educational functions. The role of navigators overlaps with brokers' traditional role in helping purchasers to pick plans and enroll, although the role and compensation for navigators (who the ACA suggests will be funded through grants) do not fit traditional producer compensation schemes. Navigators will also perform outreach, especially to hard-to- reach populations, provide information on reform to low-income populations, many of whom will qualify for Medicaid and CHIP, rather than tax credits in the exchange, and help clients through a sometimes daunting eligibility determination process. However, there is nothing to preclude brokers from fulfilling this role, and the state may elect to allow brokers to participate in this program.

For both traditional brokers and navigators, the exchange will need to provide training and certification, a dedicated portal to access exchange services, and dedicated customer service support. The broker support and oversight process is a complicated one. While working with brokers will be crucial to the success of the exchange, understanding brokers' roles and relationships with carriers is a skillset not readily available outside the world of agents and plans. The exchange does some things that brokers traditionally do—such as set forth plan options for buyers and provide comparative insights. Further, brokers typically work for and are paid by carriers as "producers," but this model may or may not fit Washington's exchange. The exchange will need to evaluate existing broker compensation methodologies to determine the appropriate model for Washington.

For navigators, whether inclusive of brokers or not, the exchange will need to both encourage navigators to pursue a broad range of outreach and educational services on health reform, as well as measure and provide oversight of navigator performance, including "productivity." While ACA defines a whole new role for "navigators," many states do have experience working with application facilitators and consumer advocates who play related roles with respect to Medicaid and CHIP. A critical consideration related to the navigator function is that federal grant funding is not available for this program, so the state will need to identify alternative revenue sources to support this program.

12. Qualified Health Plan (QHP) Certification

The ACA requires exchanges to certify, recertify, and de-certify plans as QHPs, based on standards that are established, in part, by the federal government. The ACA also directs exchanges to require health plans to submit justifications of premium increases. While not explicitly an exchange function, there will need to be close coordination between the exchange and the state regulatory agency responsible for such issues.

13. Plan Rating System

As required in the ACA and in coordination with HHS, the exchange must implement a plan rating system for Qualified Health Plans (QHPs) to evaluate QHPs on the dimensions of quality and value. Depending on the level of detail provided by HHS regarding the plan rating system, it may be necessary for Washington to develop state-specific metrics in which to compare plans. Or even if the HHS developed model is very detailed and requires little state customization, Washington may decide to develop a rating system that is reflective of the goals of its exchange and the implementation of any health care reforms specific to the state. Developing a rating system and any related decision support tools will necessitate access to large amounts of carrier information, meaning the exchange will require data storage and analytical capabilities as well as the ability to integrate plan quality and value information with the website.

14. Risk Adjustment

The ACA creates three kinds of risk adjustment programs: a temporary reinsurance program that assesses fees on all carriers and makes payments to individual plans enrolling high-risk individuals; a temporary risk corridor program for qualified health plans in the individual and small group markets; and a risk adjustment program for issuers offering plans in the individual and small group markets. Of these three, the risk corridors program will be administered at the federal level, while the state must administer the transitional reinsurance program. The state may or may not elect to perform the risk adjustment function, or choose to have this program administered, in whole or in part, by the federal government. These programs can be carried out by the exchange, or by another state entity. If housed outside the exchange, at a minimum, the exchange will need to be able to coordinate closely with these programs.

15. Consumer protections & External Reporting

The ACA requires exchanges to carry out a number of consumer protection functions. For example, exchanges are directed to require health plans that seek to become QHPs to submit justifications for any premium increases. The statute directs exchanges to collect and disclose information from plans seeking to be QHPs, including financial disclosures, data on enrollment and disenrollment, and data on denied claims. Exchanges are also required to post information about enrollee satisfaction on their websites.

Additional operational requirements include developing a reporting system to track buying patterns, enrollee satisfaction, and problems; developing a rating system for QHPs; coordinating with Washington's Office of the Insurance Commissioner on a host of licensure and market oversight issues; updating and monitoring QHP premium rates and underwriting; and addressing consumer complaints regarding QHPs. Beyond statutory requirements, each state exchange will no doubt exercise some discretion in deciding how proactive or interventionist it will be on consumer protections.

16. Exemption Certificates & Appeals of Eligibility

The ACA assigns the exchange responsibility for certifying exemptions from the individual mandate. While the Secretary is to establish an appeals process for eligibility determinations, it is likely that the exchange will need to be able to implement this process. The exchange will also need to be able to notify employers when an employee qualifies for subsidized coverage through the exchange, thus potentially triggering an employer penalty. Carrying out these politically sensitive tasks efficiently, effectively and with considerable flexibility will be necessary to maintain and build public support for the exchange and health reform.

IV. Survey of Existing State Resources

To understand the current state resources and capabilities that might be used to inform the development of Washington's exchange, we conducted interviews with senior staff in Washington during July and August 2011. Interviewees included representatives from Washington's Health Care Authority; including the Public Employees' Benefit Board (PEBB), the Health Insurance Partnership (HIP), the Basic Health program, and Medicaid. Outside of the HCA, we interviewed staff from the Office of the Insurance Commissioner (OIC). We also interviewed third party administrators and consultants where appropriate, and reviewed source documents identified by interviewees as being of particular importance or relevance. We are grateful to the interviewees for their candid and insightful thoughts on how their programs might relate to the Washington exchange, and for generously making time to contribute to this analysis, despite their many other responsibilities and commitments.

Based on these interviews, we identified existing resources within Washington that are relevant to the development and operation of an Exchange, including several capabilities that are especially robust.

As would be expected from examining multiple organizations engaged in a similar line of business, there is high degree of existing overlap in the functions performed by these agencies. Each has the administrative and operational infrastructure required to serve individuals falling under its jurisdiction and mandate, many rely on the same health carriers to service their members, and many interface with the same or similar populations as individuals move from one entity to another to seek health insurance benefits as their circumstances and demographic profile changes over time. For the sake of brevity and clarity, we have focused our discussion of key findings below on those elements of each organization we felt were most useful and/or relevant to the development of the exchange.

Public Employee Benefits Board

Washington's Public Employee Benefits Board (PEBB) administers benefits for approximately 350,000 state, K-12 school district, and local government employees and retirees. Employees can choose to receive their health care coverage from one of two fully insured managed care plans or through the self-insured Uniform Medical Plan (UMP), which PEBB administers in partnership with Regence Blue Shield, a contracted Third Party Administrator (TPA). Approximately 60% of members are enrolled in the UMP, while the remaining 40% are split between Group Health and Kaiser. Benefits are subject to overall spending levels set by the state legislature, and the cost of coverage is split between enrollees and PEBB, with PEBB paying about 85% of the cost. As the purchasing authority for 350,000 public employees, PEBB has a wealth of experience, expertise, and infrastructure related to procuring and administering publicly-subsidized commercial health benefits. Based on their scale and experience, the authority is able to both seek competitive rates for their members, as well as to engender changes and innovations in the design of benefits, product design, and care delivery.

PEBB works closely with its contracted health plans on the development of products and benefits, and seeks to leverage its buying power to play a leadership role in developing products and benefit designs focused on the improvement of care quality, consumer choice, and shared accountability. To broaden employee choice, and in partnership with its fully insured health plan vendors, PEBB has recently introduced lower-premium benefit designs, including designs available beginning in 2012 that are attached to a Health Savings Account, and is currently working to introduce a new benefit design slated for 2013 geared toward greater shared accountability for health behavior and cost trend management between the HCA, PEBB members, PEBB health plans, PEBB providers, and PEBB employers. Through changes to service utilization, payment, plan design, and the monitoring of health outcomes, PEBB hopes to improve health status, cost trend, member satisfaction, and health care quality.

The introduction of these products, which require a substantial investment on the part of participating carriers, as well as management and oversight on the part of PEBB to ensure consistency for their members, are examples of the opportunities available to purchasers with significant amount of membership scale.

To support their contracting and plan management functions, PEBB leverages their contracting, financial analysis, and data management capabilities, which exist partly within the agency, and partly in their contracted administrative vendors. Some key functions performed by PEBB include:

1. Health Plan Procurement and Annual Rate Renewal Process

   PEBB holds five year contracts with Group Health and Kaiser to provide member coverage in PEBB-specified product designs. Rates are renewed annually to reflect medical trend, population changes, and benefit design modifications. The procurement and rate renewal process requires significant financial and actuarial analysis, which is performed in part by in-house PEBB staff, and in part by consulting actuaries engaged by the agency. In addition to establishing rates and member premiums, this process involves risk-adjustment of carrier premiums to account for potential health status differences between plans.

2. Data Storage and Analysis

   For the self-insured product, PEBB contracts with a vendor called VIPS and operates a data warehouse called MCSource that supports modeling and analysis, claims and utilization reporting, quality assurance, and end-user training. Although MCSource is a robust system, staff expressed the desire to enhance the capabilities of the data warehouse to further support more detailed clinical and financial analysis. This desire may provide the exchange an opportunity to leverage the warehouse for its own data needs.

3. Member Services and Appeals

   PEBB staffs its own customer service center to provide support to enrollees and field questions and complaints regarding eligibility and enrollment. Plan specific questions are forwarded to the specific plan. PEBB employs a staff of 12 to field second-order member issues, take walk-in inquiries, and process account adjustments. This staff accepts 7,000 – 10,000 calls per month. In addition, the agency utilizes an online tool called FUZE, which allows for member and employer inquiries to be submitted online, responded to within a couple of hours, and stored in an accessible archive to provide answer to similar questions. Separate units within PEBB monitor enrollment and eligibility requirements, manage open enrollment, and support the personnel and payroll agency staff who manage the account accuracy of employees. These issues are mostly managed by HR staff in participating agencies with training and supervision from PEBB.

4. Member Communications

   PEBB employs a communications staff to manage member and agency communications related to the UMP, as well as overall PEBB open-enrollment information. (Communications specific to the fully-insured plans are handled by the individual carriers). This group drafts and reviews all published materials and correspondence, staffs benefits fairs, and generates member information, including detailed benefit and coverage publications.

The current IT systems that supports PEBB's benefits administration function is known as PAY1. The PAY1 system is a former payroll system that is now used for PEBB eligibility, paying carriers, and collecting monies from brokered agencies. Although Wakely was not charged with performing a detailed technical review of existing IT systems, feedback from staff indicated that PAY1 may not be able to meet the needs of the exchange due to its age and inflexibility. However, the system does support a total premium flow of approximately $1.8 billion annually, and is able to support flexibility to establishing benchmark premiums and varying contribution rates across agencies. The funds flow, particularly for brokered agencies, is complex and may have some applicability to the SHOP functions of an exchange. Thus, while PAY1 may not be the solution to support the exchange's SHOP functionality, the system's requirements documentation should be reviewed during the design and technology development phase, and the vendor may be a good, cost-effective source for WA's exchange.

The exchange will also want to review the UMP's TPA relationship with Regence BlueShield. While the state manages the plan, Regence BlueShield provides the operational features such as claims processing, customer service, online member support tools, and elements of the provider network. PEBB relies heavily on the state agencies to use online tools to educate and enroll their employees, so the Regence operated UMP call center is really their only robust customer service tool. Regence, Group Health, and Kaiser all offer members a chance to review their claims, provider search, health assessment, online chat with customer service representatives, hospital comparisons, and member submitted provider reviews.

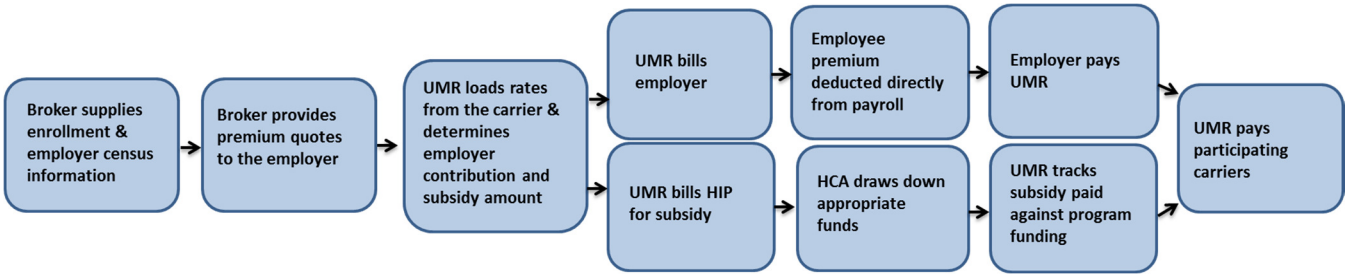
Health Insurance Partnership

Washington State's Health Insurance Partnership (HIP) allowed small employers with low-wage workers to have access to affordable health coverage in the small group health insurance market. HIP offered small employers a selection of the same health insurance plans available in the small group market with a lower employer contribution rate, and offered a premium subsidy to low-wage employees depending on their income. HIP was funded through a grant from the U.S. Department of Health and Human Services State Health Access Program (SHAP). There are currently 66 individuals, representing 16 small businesses, covered under the program. In May 2011 the program lost federal funding and is no longer accepting new members; benefits for existing members will continue through their existing plan year and then be discontinued. Although only operational for six months, HIP shared many design similarities that will be required for the SHOP exchange (including a tiered benefit design) and there are many areas of functional overlap with the primary exchange business areas that should be explored to inform exchange development. Wakely found particular promise in the relationships HIP had cultivated with its TPA, brokers, and the participating carriers.

HIP uses a third party administrator, UMR, for its application, employer eligibility, enrollment, and billing functions. UMR works directly with the employers, carriers, and brokers participating in HIP. UMR collects employer information and determines eligibility, monitors ongoing account activity, and also determines employee eligibility for subsidies. Once eligibility is determined, the employer is directed to a broker, who assists the employer in completing the enrollment process by providing quotes and assisting the employer to select a plan. Once they have selected a plan, ongoing billing, account management, and customer service are handled by UMR. Since not all employees qualify for subsidies, the billing and collections for HIP require a great deal of coordination. UMR uses enrollment information from the broker to determine a premium amount for each employee, bills the employer, and requests a subsidy from HIP. Employee premium is deducted directly from payroll. After HIP is billed for the subsidy, HCA will draw down the appropriate funds. UMR actively tracks the subsidy payout against total program funding.

While there is some procedural/process overlap, many of the eligibility and enrollment functions are part of a manual, broker driven process that does not seem to meet the level of automation needed by the exchange. The TPA infrastructure was designed to be scalable in order to support an anticipated growth in membership, but there are similar, more robust systems within the state that could perform similar functions. However, the funds flow between UMR, employers, HIP, and the carriers closely parallels processes that will need to be administered by the SHOP exchange, and should be closely examined by the exchange when developing this functionality. The business experience of HIP staff, as well as, potentially, the experience developed by UMR, may be important assets to leverage as the exchange designs and develops its SHOP components.

Figure 1. HIP Process Flow Diagram



Since HIP could not perform the quoting and rating functions necessary to facilitate enrollment, every participating employer had to work through a broker. Therefore, creating and maintaining relationships with participating brokers was critical to the success of HIP. HIP developed a detailed training program that brokers had to complete prior to being included on the preferred list of producers maintained by HIP from which employers could select brokers to work with once determined eligible. Broker commissions were paid by the carriers at the same rates as the commercial market. However, when the program was near implementation, most commercial carriers in Washington had recently cut commissions entirely to groups of five or fewer employees, which limited the willingness of some brokers to participate in the program. Others, however, continued to serve and support employer clients. The experience of HIP in working with brokers should provide a great deal of insight to the exchange as it develops its policies related to broker interaction and management. Concretely, through the HIP, the exchange can access a list of brokers that are already familiar with a SHOP-like model, as well as a smaller subset who are most likely to actually want to work with the exchange.

The HIP employed a number of features that mirror components of the SHOP exchange and that could help with the design and implementation of the exchange. For example, the HIP utilized online tools for employers, such as an online cost calculator and subsidy gauge, handled appeals of employer eligibility, and conducted stakeholder engagement as it relates to carrier participation. The relationships formed with carriers, small-business organizations, and public agencies, which were all heavily involved in the HIP development process, may help the exchange build engagement and acceptance of the SHOP exchange. Similarly, the experience of marketing the HIP to businesses should provide some valuable lessons that will help the exchange in their marketing efforts to small employers.

Basic Health Plan

The Basic Health Plan subsidizes private health insurance coverage for individuals, low-wage employees of private employers, and families with children in Medicaid (through Basic Health Plus) whose income is below 200 percent of the federal income guidelines and who are not eligible for Medicaid or Medicare. Basic Health enrollees pay a minimum monthly premium of $34, in addition to an annual deductible and coinsurance subject to an out-of-pocket maximum; the BHP subsidizes the remainder of plan costs. Basic Health enrollment peaked at over 100,000. Budget constraints led lawmakers to reduce BHP enrollment by 43 percent in the 2009-2011 budget cycle and introduce a waiting list. Now enrollment is at 37,000 with a waiting list of 252,000 people.

To support the financial management and premium billing functionalities required to collect money from enrollees and provide payments to participating health plans, Basic Health uses the Member Billing and Management System (MBMS). Basic Health is the only program that uses MBMS, which handles eligibility, enrollment, and billing needs, and leverages some components of the PAY1 system controlled by PEBB. While MBMS adequately supports the

Basic Health business needs, feedback from BHP staff indicated that it will likely not meet the ultimate goals of the exchange, which include web-based and self-service functionality. However, the financial model underlying this system may provide some important guidance to the exchange, particularly on the administration of premium tax credits.

The funds flow, eligibility interface, and billing functionality performed by MBMS are robust and apparently unique in the market place. After eligibility determination and enrollment is performed, a record is created in MBMS. MBMS then sends notification to PAY1, which will store the member account balance. MBMS automatically reads the account balance and sends the member an invoice. After payment, PAY1 sends the 820 to the carrier and MBMS sends the 834. This system allows Basic Health to bill individuals, participating employer groups, and also pay carriers all at the same time. Dual system interaction would allow the exchange to bill an individual for buying up from the benchmark plan and bill the group simultaneously. The MBMS system could be modified to perform this function, but staff expressed concern over whether the system would really meet the needs of the exchange. Basic Health staff also expressed their frustration over the unavailability of a similar system in the IT marketplace. Basic Health has put their billing system out to bid multiple times, but have never found a vendor that was able to design a premium billing system to meet their model. Exchange leadership should consult with Basic Health staff on MBMS to inform their design and thinking about an exchange billing system.

For 2012, the BHP is currently preparing a joint procurement with Healthy Options (Washington's Medicaid MCO program). While the purchase will jointly cover both programs, each program will constitute its own risk pool.

In addition, since changes in the program structure mean that premium cost is no longer an enrollment driver in the program, Basic Health is experimenting with using creative provider network/capacity strategies to incentivize enrollment in participating health plans.

Medicaid and Apple Health for Kids

Medicaid is a program that provides health coverage to low-income Washington residents, including families with children, pregnant women, medically needy individuals, the elderly, and people with disabilities. Washington's Medicaid program was recently moved from The Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). The program serves over 1 million recipients, 50 percent of whom are enrolled in managed care. Medicaid FFS expenditures in Washington for the state fiscal year totaled $4,200,000,000. Medicaid offers the exchange capabilities in the areas of navigator management, eligibility determination, enrollment, customer service, and outreach.

Medicaid, in its Apple Health for Kids program, has significant experience with navigator-like enrollment assistance. This program was created to compensate selected community groups for assisting families with enrollment into the program. Compensation was tied in part to the number of children the community group successfully enrolled into the program. Enrollment

assistance was provided by one designated community partner or public health official per county. Staff members were able to track where applications came from through a barcode attached to all electronic and paper applications. Medicaid used population surveys to measure effectiveness of the program. Although supervising staff felt there could be improvements in the compensation model, they felt the program did enhance accountability for community outreach efforts, and both the program and the community groups were happy to have information on application status and ultimate determination of a case.

More can be learned through interviews with the community partners that participated in this program, as these groups may be able to provide valuable insight on what worked, what didn't, and particular geographic and demographic factors for the exchange to consider when developing a navigator program.

The customer service platform for Medicaid members (post-eligibility) and providers is built from the state's MMIS system – Provider 1. Staff mainly handles application, card, and FFS issues from members, as well as full provider customer service including credentialing and claims. This platform offers very sophisticated IVR and CRM tools. Provider 1 also offers flexible reporting, data management, and carrier functionality. However, the billing/financial capabilities of the system still need to be assessed. Medicaid does not currently use the system for its billing/collections needs, but rather utilizes the Aquity system at the Division of Child Support (a system that does not offer the varied means of payment needed by the exchange). Provider 1 is also not designed to receive any provider network information from carriers. More analysis would need to be done in order to completely understand which functions Provider 1 could assist with. Also, based on staff feedback, it was apparent that integrating customer call center functionality between Medicaid and the exchange would be challenging. Should the state elect to rely on Provider 1 for some functions of the exchange, whether and how the exchange should centralize call center functions across health programs would require further analysis. One option would be to utilize the IVR functionality and one centralized toll free number that would direct the customer to specialized call centers (including at the exchange).

Department of Social and Health Services

The Washington State Department of Social and Health Services (DSHS) determines eligibility for Medicaid using the Automated Client Eligibility System (ACES). ACES is a legacy system that determines eligibility for cash, medical, and food assistance programs. ACES appears to be one option to achieve integration and operability between Medicaid, the exchange, and social services. However, staff from the exchange, DSHS, and Medicaid will need to carefully assess the required timeline, functionality, and competition for internal business and technical resources that are needed to make the required technological enhancements to support the exchange.

DSHS is also developing a web portal called Washington Connection that helps low-income families and individuals apply for and access a variety of subsidized programs. Through Washington Connection, residents can learn about and apply for food, cash, and medical assistance; child care subsidies; long-term care services and support; and drug and alcohol treatment. The portal allows existing members to report changes in their circumstances, initiate eligibility reviews, and access their benefit account (where members can review application status and manage their account information). Washington Connection currently links with ACES, but a separate rules engine is being developed for use on the site. The goal of Washington Connection was to offer one unique member portal for state services, including health care. Because of the "no wrong door" requirement of the ACA, the exchange must evaluate whether and how they will need to link to Washington Connection.

The Office of the Insurance Commissioner

The Office of the Insurance Commissioner (OIC) performs a wide range of regulatory, oversight, and consumer protection functions that touch on multiple aspects of the commercial insurance industry. The agency works to protect consumers, collect and distribute information, monitors the solvency of insurance companies, and oversees insurance product development and pricing. The OIC is funded through an administrative fee assessed on insurance companies and revenue generated from broker licensure fees. Because the OIC already performs extensive regulatory and oversight functions for the health insurance market, and also holds responsibility for the implementation of several aspects of the ACA in Washington, the exchange will need to work closely with the OIC to coordinate the implementation of reform, minimally, to ensure the two bodies are working in coordination at not at cross purposes. In addition, as the agency possesses significant regulator infrastructure, there may be additional opportunities to leverage this asset more specifically through collaboration on some consumer or regulatory functions. In particular, Wakely believes the exchange should further explore opportunities to collaborate with OIC as a resource on broker credentialing, consumer protections and outreach, plan rating and product review, risk adjustment, and transitional reinsurance.

Activities performed by the agency include:

- Company Supervision and Market Oversight: This function includes the licensing, certification, and auditing of the 56 insurance companies based in Washington State, and monitoring the other 2,144 authorized to do business here. The OIC must assess the financial solvency and provider networks of each carrier as part of the licensing process. The OIC also conducts an annual analysis of the entire insurance market.
- Producer Oversight: The OIC controls the licensing and education of all agents and brokers in Washington.
- Product Oversight and Rate Review: The OIC reviews and approves specific plan and rates filed by the insurance carriers. This analysis includes a rate review process staffed by on site actuaries.

- Consumer Protection: Through a network of community groups, volunteers, and in-house staff, the OIC monitors complaints/appeals from consumers and also performs consumer education.
- Enforcement: The OIC has a legal unit charged with the investigation of producers and carriers. They also recover money for consumers with insurance disputes (the agency recovered $9 million in 2010).

As the entity charged with overseeing Washington's insurance market, the OIC performs a number of information gathering, analytical, and reporting functions that are analogous to the more "regulatory" aspects of the exchange's business requirements. For example, the OIC collects and reviews a significant amount of information from carriers as part of their licensure, rate review, and product review processes that would be similar to the "credentialing" or "qualification" aspects of the QHP certification. It also makes public a significant amount of information related to plan activities, products, and financial position of health plans that is similar to the type of public reporting and quality reporting that will be required of the exchange. Similarly, the agency, as part of its rate review process, collects and subjects to actuarial analysis plan pricing, premium, and financial performance information that, while not encompassing the full scope of functionality that would be required to operate a state-run risk adjustment program, has many similar features.

The OIC also holds responsibility for licensing and overseeing the activities of the state's insurance producers, including brokers. The OIC has an online self-service portal for brokers to apply and pay for their licenses online. This web tool also contains links to all associated training materials brokers need to review in order to operate in Washington State. A list of certified brokers is available on the web as a comparison tool for consumers and carriers to use. The OIC also provides broker oversight and enforcement, which includes a consumer protection function as well as intensive work and relationships with brokers, carriers, and consumers. This structure and expertise may be valuable to the exchange as it develops a strategy and approach to working with and managing this important stakeholder community. Feedback from OIC staff indicated that their experience would not lend itself to contributing to the management of navigators (another type of producer for the exchange) but that their broker oversight and enforcement team could certainly provide the exchange with the knowledge base needed to work with the broker community.

In addition to its analytical and licensure activities, the OIC oversees several consumer outreach, information distribution, and grievance support functions to help consumers navigate the insurance market. One such program is SHIBA, a statewide network of volunteers that provides assistance to residents accessing health services and was started primarily to assist individuals gain access to Medicare benefits. The program is funded by an administrative fee on carriers and supplemented with federal funding. The program operates with the assistance of 400 volunteers, who are recruited, trained, and managed by a network of 20 community organizations located around the state. SHIBA's network of volunteers could potentially be trained to be navigators. The program may also provide a model for performance measures for navigators. The OIC uses a web application to obtain data from volunteers and organizations to send to CMS as part of their reporting requirements, but the agency also uses the data to measure consumer satisfaction.

In addition to SHIBA, the OIC has 8 analysts in house that staff a call center for consumer questions about insurance and appeals. These analysts use a detailed case management system to track consumer interaction, which is also used by the OIC to measure satisfaction. Future outreach plans include a system that notifies consumers via email when their plan files new rates. The OIC was the recipient of a consumer assistance grant from CCIIO. Staff is using that grant money to organize an IT infrastructure to create a stronger referral process between different programs and agencies. SHIBA, the OIC call center, and/or consumer assistance program may provide valuable insight for the exchange as a model. Due to the regional and geographic differences in Washington, having these existing community resources could prove vital. Also, the consumer satisfaction data compile by the OIC will have to be shared with the exchange to assist in the measurement and rating of QHPs.

V. Summary of Key Findings by Core Work Process

Based on Wakely's review of existing state health programs, the following section will highlight the key elements identified that warrant further study to determine whether the existing capacity will be able to support exchange functionality. The section is organized by core work process to identify elements from the agencies examined that will potentially support each process.

Table 3. Summary of Key Findings by Core Work Process

Core Work Process	Existing Washington Resources Warranting Closer Examination
1. Oversight, Governance, and Program Evaluation	• The exchange will establish its own independent governance and oversight structure, but will work closely with associated agencies and existing workgroups. • A number of independent boards and authorities exist in the state and they may provide a template for governance model and board practice.
2. Internal Administration	• The HCA currently provides the exchange with payroll and human resources services, as well as employee benefits, IT infrastructure, office space, and furniture and fixtures. Once the exchange becomes independent, it may elect to continue using some state elements, such as employee benefits and HR functionality. Relying on the state for some of these functions may be cost- effective in the short term while exchange staffing needs remain uncertain. • The exchange may want to use existing HCA policies and procedures as a template for administrative and HR practices.
3. Financial Management	• Although the exchange will establish financial independence and hold custody of its own funds, leveraging existing state banking relationships or investment funds may provide a cost effective means to manage exchange cash and investments. • Currently, the exchange is reliant upon HCA for accounting, financial reporting, and internal financial control functions. Existing state policies and procedures could provide a starting point for the development of similar protocols within the exchange.
4. Eligibility Determination	• PEBB, HIP, Basic Health, and Medicaid all determine enrollee eligibility separately. The systems utilized differ in scale and level of complexity, but none currently has the functionality needed to provide the full scope of exchange eligibility needs without substantial remediation. However, feedback from staff identified the ACES system under DSHS as an asset that could be modified to support exchange eligibility requirements. • Administration of the premium tax credit is a function unique to the exchange and is not performed by other health care agencies.
5. Premium Tax Credit Administration	• The MBMS system under BHP may provide guidance for the design phase and/or requirements definition with respect to administering funds flow, one component of the tax credit administration functionality. • No existing web portal currently exists that provides the full scope of exchange-required service, including eligibility determination, automated plan comparison, decision support, and rating mechanism. However, certain elements that are similar to discrete functions required for the exchange web portal exist in a number of different areas.
6. Website & Online Shopping	• PEBB displays plan benefits and costs online for its members, and provides enrollees with online account management and customer self- service tools, such as the FUZE inquiry interface • HIP provides online services that help employees find a qualified broker, lists different plan designs for comparison (without a price comparison), and provides some online decision support tools including a subsidy estimator.

	• The OIC provides a wide range of information for consumers related to brokers, carrier, and insurance coverage
7. Enrollment, Billing, and Collections	• PEBB, Basic Health, and HIP all perform enrollment and billing functions similar to the exchange. However, this infrastructure is geared toward the operation of each individual program and would require substantial remediation to support the exchange. Also, because these systems are currently supporting exclusively individuals or groups, the exchange would need to assess the ability of any individual or combination of systems to support both the SHOP and the Non Group exchange. • Of existing billing systems, the billing and enrollment functionality employed by HIP, as well as the MBMS system utilized by BHP, offer the most comparable functionality to what would be needed for the exchange. • Although it is not currently used to perform billing and collection functions, feedback indicated that Provider 1, the state's MMIS system, possesses the functionality to support these activities.
8. Customer Service	• While all programs operate some form of call center/customer support, none seem to meet the requirements of the exchange. It is critical to the exchange's commercial success that it establishes a brand and reputation for high customer service for a diverse population. An important component of this is to create a sophisticated and real time referral mechanism with any existing state call centers to ensure that the exchange meets the federal "no-wrong door" requirement for seamless customer service between Medicaid and the exchange. • A number of agencies contract vendors to provide this service, including HIP (UMR) and PEBB (Regence). Current contracts with UMR and Regence should be reviewed as models for customer service and/or performance measures. • Given the multitude of entry points, particularly for individuals accessing subsidized coverage, Wakely recommends a thorough analysis of customer service functions and customer interfaces to help the exchange better understand the customer service entry points currently available for consumers and options that exist to ensure the consumer experience is as simple as possible across agencies.
9. SHOP Specific Functions	• The enrollment, billing, and employer/carrier interfaces developed by HIP and UMR are most similar to the functionality that will be required to operate the SHOP. However, key functions, such as the automatic generation of quotes, employer account management, and automated broker interface, do not currently exist. • PEBB performs some employer benchmarking and contribution adjustments, as well as rate compositing functions. The MBMS system operated by BHP performs billing, collection, and interface to eligibility that is similar to operations performed by the SHOP.

10. Outreach & Marketing	• PEBB has a communications staff that manages the creation of member materials, open enrollment publicity, and benefit guides. • HIP has developed strong stakeholder relationship with small businesses, carriers, and the broker community, as well as experience, through a vendor in developing information and marketing materials for small businesses. • The SHIBA program, operated by the OIC, includes a network of volunteers and community organizations that would be a useful asset to help spread the message about the exchange to the uninsured. The OIC also holds data on insurance take up around the state that could be useful for the exchange to target Outreach/resources to the places their most needed. • Medicaid and DSHS have strong existing relationships with community organizations and local entities throughout the state. This community presence and experience will be valuable to support exchange outreach efforts.
11a. Broker Management	• The OIC performs credentialing and oversight for brokers and other producers that the exchange may be able to draw upon. • HIP developed a broker training program and materials to support the programs SHOP-like functions. They also developed (a) a list of qualified brokers and (b) a shorter list of brokers with a strong interest in participating in a state-subsidized program.
11b. Navigator Management	• Medicaid's experience working with community groups and tracking enrollment performance with Apple Health for Kids can provide important lessons and specific tools. Washington is one of the few states who have experimented with compensation and evaluation of its community groups in this way and this experience could be a valuable asset to the exchange.
12. Qualified Health Plan (QHP) Certification	• PEBB, Basic Health, Medicaid, and HIP all have experience procuring health benefits for public programs, and PEBB, BHP, and Medicaid are currently active purchasing agents interfacing with carriers in the market. PEBB has extensive experience working with carriers on benefit design and product development, as well as analytical infrastructure to assess plan bids and rates. HIP engaged in an extensive benefit design and plan tiering exercise to select plans and benefit designs to offer to small employers. The exchange will want to understand existing carrier relationships with other health programs, as well as utilize their contracting and management experience/expertise. • The OIC collects and reviews a large amount of data from carriers as part of their rate review, market oversight, and consumer protection functions, including premium cost, financial solvency, medical trend, provider contracting, and customer satisfaction. As this data collection and plan assessment will be an important element of the certification process, their capacity and/or expertise may be valuable assets of the exchange.
13. Plan Rating System	• PEBB has data warehousing and information analysis capabilities specific to the UMP that is a common source for reporting and benchmarking activities.

	• The OIC collects and reviews a large amount of data from carriers as part of their rate review, market oversight, and consumer protection functions, including premium cost, financial solvency, medical trend, provider contracting, and customer satisfaction. They also publish a significant amount of public information related to plan performance and key statistics. • Again, a common plan rating system could prove useful and efficient.
14. Reinsurance and Risk Adjustment Program	• PEBB performs basic risk adjustment, but it is specific to its own, captive risk pool and limited to the three health plans offered by the agency. • The OIC performs a portion of the duties that would be required to operationalize a risk-adjustment program, including a collection of carrier premium information, benefit level, and loss ratios. However, they lack some of the more detailed analytical capacity, such as a claims warehouse and risk adjustment model, which will be required to manage such a program, should the state elect to do so. • The OIC performs a wide range of consumer protection and public reporting functions related to health insurance coverage and consumer experience. The entity not only has the experience, but also many of the data collection and review processes necessary for adequate analysis and tracking. Therefore, the exchange may want to link or populate this information on theirs.
15. Consumer Protections & External Reporting	• There is a component to the reporting function that will be highly exchange specific (i.e., related to the operations and performance of the exchange and its target population) for which no current capacity exists outside the exchange. • In their capacity as regulator and consumer oversight bureau, the OIC has multiple groups tasked with collecting, reviewing, and disposing of consumer grievances and appeals related to their health insurance coverage. As the appeals function is a primarily process-driven endeavor, coordinating with or leveraging the OIC's expertise with respect to this regulatory function should be strongly considered.
16. Exemption Certificates & Appeals of Eligibility	• Similarly, Medicaid has an appeals process related to eligibility determination that is relevant for individuals seeking coverage through the Non Group exchange. • Although not encompassing near the scale that will be required for the exchange, HIP does have some experience dealing with the type of employer related appeals concerning eligibility that will be filed and developed plans for scaling this function up based on anticipated growth.

Appendix 1. Conceptual Framework for Exchange Decision Making

Discussion of Key Considerations

Washington State has a large number of publicly sponsored health care and health oversight programs. As would be expected from multiple organizations engaged in a similar line of business, there is certain degree of existing overlap in the functions performed by these agencies, as each has the administrative and operational infrastructure required to serve individuals falling under its jurisdiction and mandate, many rely on the same health carriers to service their members, and many interface with the same or similar populations as individuals move from one entity to another to seek health insurance benefits as their circumstances and demographic profile changes over time.

By bringing three major health care programs under the umbrella of the HCA, Washington has taken steps toward consolidating the governance and operations of some of the major health care programs in the state. As the integration between Medicaid, BHP, and PEBB matures, we would expect the state to gradually increase the level of operational integration between these three programs. Some current efforts, such as the joint procurement of Medicaid and BHP managed care plans, suggest that the state is already moving in the direction of enhanced collaboration and integration between health insurance programs. The introduction of the exchange, therefore, raises important questions related to how the new organization will or will not relate to existing state programs.

While we have identified several existing and highly functional administrative and operational systems, processes, and areas of expertise that relate to required functions of the exchange, the extent to which these elements can or should be incorporated into the state's efforts to develop the exchange is dependent not only on whether these items exist, but on several additional factors that must be carefully considered. We have outlined some of these considerations below, as we believe they are central to identifying which components, if any, can or should be incorporated, shared, or repurposed for assistance in meeting the requirements of the exchange. We also share the following considerations to highlight the criteria we used to develop our recommendations, which are presented in the next section of this report.

1. Opportunities for Administrative Efficiency

   The most obvious reason to consider leveraging existing infrastructure is to achieve administrative efficiencies in not having to re-create functions from scratch, or to achieve greater scale efficiencies from the state's existing fixed costs. To assess the level of efficiency, the state must perform a cost/benefit analysis to weigh the pros and cons of remediating existing systems or processes to serve the needs of the exchange, which should include an assessment of how close the component is to being able to service

the exchange, what functionality will be gained or sacrificed to repurpose or adopt the element, as well as the non-financial considerations, described in part below.

2. Functional Criticality, and/or Uniqueness

How critical and/or unique a function is to the exchange will have a strong impact on whether the organization seeks to re-use, share, or rely on an existing entity to help support the function. To help structure the assessment of different components, it is useful to group functions into one of three categories as illustrated with examples in the figure below. Functions deemed as critical to the exchange, while unlikely to be shared with an outside government entity, may still be outsourced to a Third Party Administrator or another vendor contracted to the exchange.

Figure 1. Criticality and Uniqueness of Exchange Functions

Critical Function, Unique to the Exchange	Critical Function, Similar to Other Programs	Secondary Function, Similar to Other Programs
• Tax Credit Administration • Broker Compensation • Carrier interface for SHOP Functions	• Eligibility Determination • Customer Call Center • Health Plan Certification and Benefit Design	• Transitional Reinsurance • Producer Credentialing

Items that fall on the left-hand side, such as tax credit administration, are both critical functions of the exchange and unique to exchanges, and therefore unlikely to be found in existing programs. Items at the far right are less critical business functions of the exchange, and therefore strong candidates to share or rely on existing programs if available. Those in the middle will require careful consideration, as they are both critical to the program, yet similar to functions performed by existing programs. Thus, while potentially technically capable of being used in some way, the exchange will need to identify on a case-by-case basis which should or should not be utilized.

3. Potential for Market Confusion and/or Frustration

For many functions, mostly related to QHP certification, but also including regulatory interfaces with businesses and individuals, and data acquisition to support exchange analytics and risk adjustment, the exchange will interface with the same parties and for similar purposes as other current programs. Finding ways to consolidate, coordinate, or streamline these interactions may prevent market confusion or frustration on the part of businesses or carriers now interfacing with several different state agencies.

4. Autonomy vs. Integration

Although less conducive to empirical analysis than other dimensions, finding the appropriate balance between autonomy and integration will be one of the most critical considerations for the exchange as it moves down the challenging timeframe towards ACA implementation and develops a strategy for positioning itself within the state and in relation to both the market and existing programs. As illustrated under consideration (2), above, the exchange is likely to seek greater levels of autonomy relative to items situated on the left-hand side of the criticality scale, as well as for items related specifically to key strategic and governance components of the exchange.

Recommendations

Based on Wakely's review of existing state infrastructure and review of relevant state agency capacity, as well as the key considerations outlined in the previous section, we offer the following recommendations as areas for further exploration and consideration by the exchange. Please note that these recommendations are draft and preliminary, and will be further refined and developed in collaboration with exchange staff as this document is prepared for final review.

Table 1. Criticality and Uniqueness of Core Work Processes

Major Business Area	Core Work Processes	Critical Function & Unique to HIX	Critical Function, Similar to Other Programs	Secondary Function, Similar to Other Programs
Exchange Governance & Administration	1. Governance & Oversight	✓		
	2. Internal Administration	✓		
	3. Financial Management	✓		
Operational Systems	4. Eligibility Determination		✓	
	5. Premium Tax Credit Administration	✓		
	6. Website & Online Shopping	✓		
	7. Enrollment, Billing & Collections		✓	
	8. Customer Service Call Center		✓	
	9. SHOP-specific Processes	✓		
Communications	10. Outreach & Marketing	✓		
	11. Broker and Navigator Management	✓		
QHP Certification	12. Qualified Health Plan (QHP) Certification		✓	
	13. Plan Rating System		✓	
Regulatory & Reporting	14. Reinsurance & Risk Adjustment Program			✓
	15. Consumer Protections & External Reporting			✓
	16. Exemption Certificates & Appeals of Eligibility			✓

Note: Each core work process consists of several activities and processes. Within any given process, there are some functions that are unique and critical, while others could be done in coordination with a separate entity. Additional refinement is required to assess these functions at a more detailed level.

Regulatory Functions

The most salient issue that emerged from our review of existing state programs is related to the need on the part of the exchange to determine how it should balance its role as a market actor and business partner with the regulatory requirements specified in the ACA. In particular, this issue touches on the potential relationship between the exchange and the OIC, which, while potentially complex, may be important to the success of the exchange, as well as potentially fruitful for both agencies if they are able to harness and coordinate their complementary capacities.

The major business functions required of the exchange encompass both business and administrative functions more analogous to a private company, as well as public-facing and reporting functions more similar to a government agency. This is true at the level of core work processes, as well as within each core work process. For example, the broker management function involves a credentialing and oversight function familiar to government oversight authorities, as well as a business relationship similar to that which exists between a company and its commission-based sales force. Similarly, the QHP certification process blends the regulatory functions of compliance verification and credentialing with the business functions of strategy and market positioning. Although at times advantageous to play both roles simultaneously, doing so can also create challenges for the exchange in its interactions with the market and other authorities.

The determination of how to appropriately balance these two roles should include a consideration of the ways the exchange may choose to collaborate with the OIC, which currently performs some similar functions to items required of the exchange and is currently tasked with implementing some additional key components of the ACA. Regardless of whether the exchange elects to leverage the OIC in the performance of its duties, the two agencies will need to work closely together on a host of issues on an ongoing basis and the OIC's regulatory expertise and capacity may be an important resource for the exchange. Although a detailed review of the ways in which the two agencies could potentially collaborate is beyond the scope of this document, we will provide some specific examples of areas and ways that such a partnership could be handled by focusing on QHP Certification and Broker Management. Other potential areas to explore include Risk Adjustment and Reinsurance, Consumer Protections and Reporting, and Exemption Certificates and Appeals of Eligibility.

In certifying, decertifying, and recertifying Qualified Health Plans to participate in the exchange, the exchange performs a both a compliance monitoring role in approving plans for sale through the exchange as well as a vendor role in providing a sales outlet for the sale of insurance and providing related administrative functions. There are a number of critical components that go into the QHP certification process, but a few of the major functions include a strategic vision, goal setting, and decision making function; an operational and technical interface component; and a credentialing function that involves significant amounts of data collection, review and analysis. Based on the OIC's existing infrastructure to support data collection and analysis, as well as its existing regulatory role in monitoring health plan performance, the agency could provide

assistance in relation to the third of these functions, while its work would be an input to support the development of the first two. This would also prevent the duplication of effort on the part of carriers by maintaining a single flow of information, and clearly delineate the regulatory vs. operational responsibilities performed under the program.

A similar distinction in roles could be applied to the oversight and management of brokers participating in the exchange. This function again involves both a credentialing and oversight role as well as a market-facing, business relationship focused on selling insurance. Following a similar logic to that employed relative to QHP certification, the exchange could rely on the OIC's existing credentialing and oversight capabilities to certify and credential qualified brokers, while maintaining internal management of its own broker management, outreach and operations.

Regardless of how closely integrated the exchange seeks to become with the OIC, we believe it to be one of the organization's critical relationships, and one that necessitates close coordination.

Core Systems

Regardless of the approach elected by Washington for the development of its exchange systems, these systems must interface with and be integrated into existing state programs to comply with eligibility requirements of ACA. Approaching the systems in an integrated fashion (e.g., running the exchange and Medicaid through the same eligibility system) makes sense from a cost standpoint, as the state should realize economies of scale from leveraging the same technical infrastructure for a larger population. However, the opportunities for administrative efficiencies must be balanced against the criticality and uniqueness of the functions being discussed. Given the strategic and operational important of core IT systems for the exchange, as well as the new and unique functionality required to operate the exchange, we recommend that the exchange maintain a high level of control, ownership, and oversight of its core IT systems. In areas where joint operation is employed (e.g., eligibility), the exchange should maintain a strong voice in the design and operation of the system to ensure it is structured in a way that meets the requirements for exchange functionality.

An additional issue the exchange may wish to consider is whether or not to integrate the SHOP and non-group exchanges from a systems and/or vendor perspective. Because the SHOP exchange in Washington will likely be quite small, this may provide scale economies for the SHOP exchange.

Based on our experience running an exchange, as well as observations of the market, we have found a particular lack of solution related to a billing system that is able to interface cleanly with a dynamic eligibility system and provide the type of solution required by the exchange or similar state programs. These observations were echoed in our discussion with BHP, which has significant experience in working through some of the relevant issues.

Customer Service

There are a large number of customer call centers currently run or managed by health programs within Washington, and the connectivity and overlap between these programs is extensive and complex. At the same time, customer call center functionality is widely available from vendors in the market, with a wide array of firms able to provide high quality product on a cost effective basis. Thus, while we would suggest that the exchange seek to outsource this function, given the extensive overlap between populations and functions across state agencies, developing a detailed strategy for how these numbers and/or call centers relate to each other will be critical to providing streamlined, high-quality customer service across programs within Washington.

Appendix 2. Staff Consulted for Resources and Needs Assessment

Staff consulted for Needs and Resources Assessment		
PEBB	• Mary Fliss • Barb Scott • Renee Bourbeau	
HIP	• Beth Walter • Shannon Hannan (UMR)	
Basic Health	• Preston Cody • Christy Vaughn • Eileen Harris • Bob Longhorn	
Medicaid	• Manning Pellanda • Mary Wood	
OIC	• Barb Flye • Leslie Krier • Gayle Pasero • Jeff Baughman • Dave Marty • Carol Sureau	• John Hamje • Janis LaFlash • Mary Childers • Lichiou Lee • Andrea Philhower
HCA	• Beth Walter • Molly Voris • Richard Campbell • Cathie Ott • Andrew Cherullo • Annette Meyer	• Karen Glabas (Cambria) • Jason Leung (Cambria)